C CO Says He Was Foiled in Case That Led To Civil, Criminal Resolutions With $646M

For 18 years, John Slowik worked productively for a subsidiary of Olympus Corp. of the Americas, a distributor of endoscopes and other medical and surgical equipment, but he said things went downhill when he was appointed chief compliance officer late in the game. His efforts to address troubling practices — which allegedly included giving hospitals and physicians grants and consulting fees to get their business — were stonewalled and soured his “close” relationship with the CEO, according to a false claims lawsuit he ultimately filed. When the job became unbearable, Slowik took medical leave and allegedly was replaced and then terminated in 2010.

Six years later, the walls tumbled down on Olympus, which agreed to pay $646 million to resolve criminal charges and false claims allegations, the Department of Justice (DOJ) and U.S. Attorney’s Office for the District of New Jersey said March 1. Olympus resolved the civil false claims allegations and entered into two separate deferred prosecution agreements (DPAs) — for violations of the anti-kickback law and the Foreign Corrupt Practices Act (FCPA) — that allow Olympus to avoid conviction as long as it complies with reforms. If it doesn’t satisfy the requirements of the DPAs, it could be prosecuted. Also, Olympus entered into a corporate integrity agreement (CIA) with the HHS Office of Inspector General (OIG). The triple whammy reflects DOJ’s pledge to go after offending health care organizations on multiple fronts (RMC 2/29/16, p. 1).

“According to the complaint, the culture of compliance was nonexistent,” says Dallas attorney Stephen Angelette, with Polsinelli, who was not involved in the case — although he notes the whistleblower stands to make a lot of money from disclosing this information.

continued on p. 6

With CCOs in Thick of It, Hospitals Start to Address MACRA Makeover of Payments

With its web of employed, contracted and otherwise affiliated physicians, Allina Health in Minneapolis has a lot of moving parts to contend with as it heads down the road to compliance with the 2015 Medicare Access and CHIP Reauthorization Act (MACRA). The law starts to unfold next month with the first in a series of regulations, and Allina, like many health systems, will join forces with physicians to crack the MACRA methods for physician payments — the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) — which may be the largest Medicare step away from fee-for-service to fee-for-value payment methodology, experts say.

“We have a MACRA advisory group so we have the right physicians at the table to make the right decisions,” says Kate Tarvestad, senior vice president and chief compliance officer at Allina. “It’s complicated and it’s not optional, so we are trying to figure
out across the system what the implications are going to be. We are a large organization, and our structure adds a lot of complexity.”

MACRA brought an end to the “doc fix,” the annual dance by Congress to prevent a big physician pay cut, and overhauled the Medicare physician payment system. “I view MACRA as the most important acronym after the ACA,” says Anne Phelps, U.S. health care regulatory leader for Deloitte & Touche in Washington, D.C., referring to the Affordable Care Act. “This has the potential to change the way we look at delivery reform and drive value-based care from the ground up.”

Some hospitals and physicians may put MACRA on the back burner because it won’t hit their wallets until 2019. But Phelps says others are starting to prepare because CMS is shooting to release the first regulation in March—a proposed rule on the MIPS payment adjustment—and then the regulations will keep coming (see box, p. 3). What’s more, it’s too transformational to leave to the last few months. “This is an across-the-enterprise discussion,” says Phelps. “MACRA affects your position in the marketplace, your overall strategy, your relationship with your physicians and your financial and clinical risk.” And given the overhaul required for MACRA, hospitals and physicians will be thinking more broadly. Whether or not Medicare Advantage and commercial payers offer incentives to move to value-based payment contracts, it makes sense for hospitals and physicians to weigh the implications of value-based payments across payers, she says.

MACRA changes the way Medicare pays clinicians and how the payments will be updated down the road, Phelps says. “It creates separate paths for payments under the Medicare physician fee schedule,” she notes.

Until MACRA, there were only voluntary value-based arrangements, including accountable care organizations (ACOs), medical homes and bundled payments. MACRA is in another league: It’s mandatory and national because it directly affects Medicare payments to all physicians paid under the physician fee schedule. Many health systems that employ physicians or otherwise have their fortunes closely tied to them through networks or joint ventures, for example, will be affected by MACRA, for better or worse. Although Medicare’s comprehensive joint replacement program is also mandatory (RMC 12/7/15, p. 1) and puts hospitals at risk for this high-volume, high-paying procedure (see story, p. 4), it’s not national (yet).

Two Paths to MACRA

Under MACRA, physicians and other clinicians (e.g., nonphysician practitioners, clinical nurse specialists) continue to receive 0.5% annual payment updates through 2018. After that, their updates have strings attached. “To receive temporary bonus payments and higher payment adjustments in the future, physicians will have to increasingly participate in new risk-bearing coordinated care models,” Phelps says.

There are two paths physicians can take—MIPS or APMs—and some aspects are familiar. MIPS absorbs existing programs—the meaningful use of certified electronic health records (EHRs) (RMC 2/15/16, p. 1), which in 2019 will account for 25% of the “composite score” that will determine the incentive payment; value-based modifiers, which will make up 10%; and the Physician Quality Reporting System (PQRS), which will account for 50% of the payment. Also, MACRA establishes a new measure for clinical improvement activities, which rates physicians on how well they do at population health, care coordination, beneficiary engagement, expanded access, patient safety and APMs, and accounts for 15% of the composite score, Phelps says. This goes way beyond standard performance reporting, she says. It measures quality, service and utilization in expanded ways, with forthcoming regulations set to explain exactly how.
The financial implications are less murky. If physicians go the MIPS route, their payment adjustments depend on their composite scores. They could be plus or minus 4% in 2019, plus or minus 5% in 2020, plus or minus 7% in 2021 and plus or minus 9% in 2022 and beyond. Whether they fall on the right or wrong side of the percent depends on how their performance in the four MIPS categories stacks up against other providers’ scores, Phelps says. “It’s important to note that individual practitioners’ scores will be made publicly available,” she adds.

The other option is for physicians to join APMs, which is a bigger step on the journey toward an outcomes-based payment system. APMs must use certified EHRs, and their reimbursement will be tied to comparable measures (e.g., quality and clinical practice improvement), says Phelps. According to MACRA, physicians have some choices. APMs could be an ACO, something designed by the CMS Center for Medicare and Medicaid Innovation, or a health care quality demonstration. “The trick will be to determine if the requirements for new APMs align with the payment arrangements under existing delivery models, such as ACOs,” she says. “These are a lot of the activities hospitals have done before, but MACRA lights them on fire.”

Providers have upside and downside risk in APMs, and it increases as years tick by, Phelps says. MACRA calls for providers in APMs to receive 25% of their reimbursement through APMs in 2019 and 2020 and the rest the usual fee-for-service way, but that changes to 50/50 in 2021 and 2022 and then flips to 75/25 after.

There could be fluidity between MIPS and APMs because some physicians might not pass muster to stay in APMs as the revenue requirement increases, says Phelps. “Physicians might need to comply with MIPS while heading to the APM model,” she explains. If it looks like they won’t cut the APM mustard, they can head back to MIPS territory. “It is not one and done,” she explains. “The quality measures and the amount of risk an APM must take on changes over time. The payment

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**Upcoming Regulations for MACRA Implementation**

Here’s what’s coming down the pike for the revolutionary changes in the way physicians are paid (see story, p. 1). This timeline was developed by Deloitte & Touche. Contact Anne Phelps, U.S. health care regulatory leader for the firm, at annephelps@deloitte.com.

- **March 1, 2016**: Due date for comments on list of episode groups and related descriptive information posted by HHS in October 2015.
- **Apr 16, 2016**: Deadline for comments on list of episode groups and related descriptive information posted by HHS in October 2015.
- **May 1, 2016**: HHS Secretary will post a draft list of patient relationship categories and codes. Comments will be accepted from physician specialty societies, applicable practitioner groups and other stakeholders for 120 days after the draft is posted (August 13, 2016).
- **Jul 1, 2016**: Deadline for the HHS Secretary to establish through rulemaking the criteria for physician-focused payment models.
- **Nov 1, 2016**: The HHS Secretary will post an operational list of patient relationship categories and codes on the CMS website.
- **Mar 9, 2017**: Date for the HHS Secretary to establish and publish in the Federal Register an annual list of quality measures to serve as the basis for the MIPS payment adjustment.
- **Apr 10, 2017**: Date for HHS to begin providing to each MIPS-eligible professional information about items and services provided to the professional’s patients by other suppliers and providers of services.
- **Jul 1, 2017**: HHS Secretary will post a final Quality Measure Development Plan. To be updated annually.
- **Nov 9, 2017**: Due date for comments on list of episode groups and related descriptive information posted by HHS in October 2015.
- **Dec 14, 2017**: Date for HHS to begin including on all Medicare claims the new codes and the national provider number of the ordering physician or applicable practitioner.
- **Jan 1, 2018**: Date for MIPS to begin providing to each MIPS-eligible professional information about items and services provided to the professional’s patients by other suppliers and providers of services.
- **Jul 1, 2018**: MIPS adjustment announced for 2019.
- **Dec 2, 2018**: Statutory deadline for achieving national priority of widespread interoperability of EHRs.
- **Dec 31, 2018**: Deadline to begin including on all Medicare claims the new codes and the national provider number of the ordering physician or applicable practitioner.

**EHR** = electronic health record, **MIPS** = Merit-Based Incentive Payment System

Source: Public Law 114-10 (April 16, 2015)
models will start driving the delivery models. It’s a big
deal because MACRA changes the underlying payment
models and financial incentives. It applies in Medicare
but has the ability to grow in its reach as it expands to
other payers.”

Details of the quality components of MIPS and
APMs will come soon, and episodes of care will be
central to them. “It is a huge coding and compliance is-
se,” Phelps says. “CMS will define a great many more
episodes of care,” and physicians will get paid based on
them, and they will figure into the MIPS scoring. The
data will be made public by CMS, so patients will be able
to check how their physicians perform on various quality
measures, she says. “For hospitals and plans, it can affect
their revenue and their reputations.”

Because MACRA at the moment is like an algebra
problem where you’re trying to solve for X when you
don’t have Y, hospitals have to plan with their physicians
while they wait for the regulations to roll out. “Everyone
is starting to scramble because they realize they don’t
have much time,” Phelps says. “The regulations are com-
ing out in 2016, and strategies need to be put in place in
2017 before practitioners start being measured in 2018.”

Allina is moving the MACRA ball forward with its
advisory committee. It will navigate the relationships
with Allina’s employed physicians, community physi-
cians who serve on the medical staff and Allina Integrat-
ed Medical Network, a clinically integrated network of
physicians who work with Allina on improving quality
and efficiency in the Twin Cities. “The advisory commit-
te allows us to formalize those relationships more than
we already have,” Tarvestad says. It will address a range
of MACRA-centric issues, including governance, guiding
principles, requirements for MIPS/APM participation,
systems to comply with quality and other measures,
timelines and education. “I liken it to meaningful use
because it was complicated, and you needed physicians
to be engaged,” she says. “They need to report their
meaningful use measurements and milestones, or they
would lose out on the money,” which is analogous to
MIPS and APMs. The advisory committee includes phy-
sician leaders and people from the finance, public policy,
compliance, regulatory affairs and information systems
departments.

Allina has already started MACRA education across
the health system, Tarvestad says. “Hospital senior lead-
ers are an integral part of the conversation.”

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CJR Model Starts April 1; Playing Games With Care Risks Penalties

Hospitals will be in the driver’s seat when the Comprehensive Care for Joint Replacement (CJR) model starts
April 1. They take all the risk in the five-year bundled
payment program, which is mandatory for hospitals in
the 67 metropolitan statistical areas (MSAs) where the
CJR model is rolling out — about 800 of them (RMC
12/7/15, p. 1) — but can’t pull it off without physicians
and other providers.

“This will be big deal,” says Minneapolis attorney
David Glaser, with Fredrikson & Byron. “It’s weird be-
cause hospitals have the responsibility, but they don’t
have the power. Hospitals will be thinking about how
they can gobble up and control other professionals who
are providing services.”

In the five-year CJR model, hospitals alone are held
financially accountable for the quality and cost of an epi-
sode of care, which begins with admission for MS-DRG
469 (major joint replacement or reattachment of lower
extremity with major complications or comorbidities) or
470 (major joint replacement or reattachment of lower
extremity without major complications or comorbidities)
and ends 90 days after discharge from the hospital. The
episode includes related items and services paid under
Medicare Part A and Part B.

Medicare will continue to pay hospitals and their
“collaborators” — physicians, physician practice groups
and various post-acute care (PAC) providers (e.g., skilled
nursing facilities and home health agencies) — on a
fee-for-service basis. At the end of every “performance
period,” hospitals will receive an episode payment. Only

CMS Transmittals and Federal Register Regulations

Febr. 26 – March 3

Live links to the following documents are included on RMC’s
subscriber-only Web page at www.AIShealth.com. Please click on
“CMS Transmittals and Regulations” in the right column.

Transmittals

(R) indicates a replacement transmittal.
Pub. 100-04, Medicare Claims Processing Manual
• April 2016 Update of the Hospital Outpatient Prospective
  Payment System, Trans. 3471CP, CR 9549 (Feb. 26; eff. April
  1; impl. April 4, 2016)
• April Quarterly Update for 2016 Durable Medical Equipment,
  Prosthetics, Orthotics, and Supplies Fee Schedule, Trans.
  3472CP, CR 9554 (Feb. 26; eff. April 1; impl. April 4, 2016)
• Coding Revisions to National Coverage Determinations, Trans.
  1630OTN, CR 9550 (Feb. 26; eff. July 1; impl. July 5, 2016)

Federal Register Regulations

Proposed Rule
• Medicare, Medicaid, and Children’s Health Insurance
  Programs; Program Integrity Enhancements to the Provider
  Enrollment Process, 81 Fed. Reg. 10719 (March 1, 2016)

Web addresses cited in this issue are live links in the PDF version, which is accessible at RMC’s
hospitals take the risk, although they can take physicians and PAC providers along for the ride. Hospitals that hit certain quality, efficiency and patient satisfaction goals will get a bonus, and hospitals that don’t could suffer financial consequences. That will be determined when CMS compares the episode payment to an established CJR “target price.”

The November 2015 regulation finalizing the CJR (80 Fed. Reg. 73273, Nov. 24, 2015) requires hospitals to update their compliance programs to include oversight of the CJR program. They must have policies and procedures for choosing collaborators that are unrelated to the volume or value of their referrals, Glaser says. And hospital boards must oversee the CJR model.

Hospitals sign “participation agreements” with physicians and other collaborators (e.g., physicians, skilled nursing facilities, physician therapists), but they can’t compel joint-replacement patients to use any of them. “You must give patients freedom of choice,” Glaser explains, although hospitals are free to recommend providers. Hospitals also can’t require physicians and others to join forces with them in the CJR model, he says.

Patients must be given notice they are part of the CJR model. “You have to provide details of the program,” says Glaser. “There are a bunch of hoops to jump through,” such as explaining how to access their records and report quality concerns.

Hospitals enjoy only the benefits of shared savings the first year because there’s no downside risk. After that, they could be penalized for not meeting cost and quality objectives. CMS also placed limits on risk sharing with physician collaborators. Physicians get the distribution payments for decreasing costs or improving quality (but not reducing medically necessary services), and give alignment payments to help repay Medicare if they wind up owing money under the model. “The total distribution payments paid to a physician practice in a year may not exceed 50% of the total Medicare physician fee schedule payments for services to CJR beneficiaries,” Glaser says. Collaborators get nothing, the regulation states, if they’re “subject to any action for noncompliance with the CJR program.”

Voluntary submission of outcomes and risk variables data.

“Collaborators may not be able to influence all these metrics,” Glaser says. And if hospitals fall in the bottom 30% on any measure, “that probably will prevent them from receiving any reconciliation payment.”

Also, hospitals may be penalized by regulators or enforcers “if they or a collaborator do anything on the sly,” he says. That includes:

- **Steering clear of high-cost patients.**
- **Targeting low-cost patients.**
- **Over or under providing care.**
- **Failing to provide information.**
- **Restricting choice.**
- **Not enforcing collaborator agreements.**

Glaser says the penalties include ejection from the CJR program, loss of the ability to get bonuses and “having a 25% repayment amount added to the reconciliation report.”

Contact Glaser at dglaser@fredlaw.com.

**Onboarding, Exit Interviews Help Safeguard Patient Records**

New York-based Greater Rochester Neurology mailed 3,403 letters to patients of the University of Rochester Medical Center in April 2015 announcing that a URMC nurse care practitioner would soon be joining its clinic and inviting them to switch to GRN to avoid an interruption in the continuity of their care. But there was a problem — the nurse didn’t have permission to share the patients’ information with her new employer, and patients began calling URMC to ask how GRN had gotten their names.

URMC had given the nurse the list of patient names, addresses and diagnoses in March when she notified the health system of her impending departure. According to URMC, she had requested the list for her own notes, in the event that any of her old patients decided to seek treatment at GRN. URMC did not give her permission to share the list with GRN and terminated the nurse early when patients began phoning about the advertisement. URMC also created a “task force” to develop procedures to prevent similar incidents in the future, and reminded its staff that the disclosure of protected health information (PHI) is allowed only under URMC protocol.

continued
Plug Gaps in Onboarding, Exit Procedures

The key to preventing these situations is through both proper onboarding and exit policies, according to Hirsch. Employers should know if a new employee is bringing any PHI into the organization, and determine whether or not the possession and use of the data are lawful. While Hirsch says he hasn’t seen an instance in which a new employer was penalized under HIPAA, he says it’s possible if the company were to use the data knowing that they had been obtained unlawfully. (While URMC has apologized publicly to the affected patients, GRN has not made any public statements and the attorney general’s office is not saying whether it levied any penalties against the clinic.)

Onboarding procedures are much more common, Glover says, and while one might expect employers to be more knowledgeable about how HIPAA applies to the PHI new employees bring with them, it all comes down to the training that’s applied at each covered entity.

“There is a surprising lack of understanding about HIPAA, and in some respects understandably so because it’s very complicated,” she says. “This particular subject — it seems like it’s not rocket science and that people would understand.”

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The above story was excerpted from RMC sister publication Report on Patient Privacy. For more information, visit the MarketPlace at www.AISHealth.com.

Olympus Settles Big Case

Olympus, which is based in Tokyo, has a U.S. subsidiary, Olympus America, located in Center Valley, Pa., where Slowik, the whistleblower, worked. After holding a number of other positions, including director of internal audit, he became its first compliance officer in February 2009 and with one other person ran the entire compliance show, the false claims lawsuit alleged.

“Upon his appointment as Compliance Officer, Relator immediately attempted to eliminate the illegal and systemic practices” he allegedly identified, the lawsuit stated.

For example:

◆ Medical equipment giveaways and “permanent loans”: According to the lawsuit, Olympus “routinely” gave hospitals and physicians free products or let them use equipment for free, disguising this as discounts and equipment loans. “Olympus routinely provides hospitals with free products of both capital equipment including scopes, imaging products and generators and consumables and disposables such as forceps and sheaths,” with equipment costing about $15,000 to $30,000, the lawsuit alleged. “These gifts were given in exchange for the hos-
pital’s agreement to buy Defendants’ consumable products, and also to give Defendants’ products preferred status.”

◆ **Grants:** Between 2000 and 2009, Olympus sales and marketing people allegedly awarded grants to physicians and hospitals according to sales potential, the lawsuit said.

◆ **Honoraria, speaker fees and consulting fees for physician marketing:** Physicians who were asked to speak were paid whatever they asked of Olympus, which was as much as $100,000, the lawsuit alleged, with no written agreements. “In reality, Olympus was paying these physicians for using Olympus products and to promote use of Olympus products to colleagues with influence over medical device and equipment purchasing decisions,” the lawsuit alleged. The same kind of behavior was alleged when it came to physician consulting. The lawsuit contends payments exceeded fair-market value for any work performed.

◆ **Luxury vacations:** Physicians went on expensive trips to “exotic locations” on Olympus’ tab, the lawsuit alleged. “For example, Olympus would pay physicians to travel to Japan, all expenses paid, where they would stay at lavish hotels, eat expensive meals, and be entertained, all on the company dime.”

The largest went beyond physicians and “key opinion leaders” in the United States, the complaint alleged. Slowik allegedly discovered that Olympus treated physicians who practiced in foreign countries, including Canada and Mexico, to expensive trips. For example, Olympus took Canadian physicians on vacations in California but allegedly tried to pass them off as business trips to its repair facility in San Jose, the lawsuit contends. The physicians allegedly fell under the FCPA definition of a “foreign official” because health care is publicly funded in those countries, the lawsuit said. “Relator was stunned not only by the pervasive lack of education and compliance with the FCPA, but the push back from his colleagues when he attempted to cease Olympus’s unlawful conduct,” he alleged.

The lawsuit, which was amended in February 2016, alleges violations of both the federal False Claims Act and numerous state Medicaid false claims laws, including California, Florida, Illinois, Massachusetts and New York (to name a few). The premise is that the claims were tainted by kickbacks between Olympus and hospitals or physicians and therefore were false. Olympus settled this part of the case — the civil part — for $310.8 million, DOJ says.

But there’s more to this tale. The U.S. Attorney’s Office in New Jersey filed a criminal complaint charging Olympus Corp. of the Americas with conspiracy to violate the anti-kickback law. The company will be able to avoid conviction if it complies for three years with the terms of its DPA. For example, Olympus board members and executives must annually certify their compliance program is effective, and executives who engage in misconduct or fail to advocate compliance will relinquish up to three years of performance pay. Olympus also had to pay a $312.4 million criminal fine.

Olympus has more coming. In another criminal complaint, its Miami-based subsidiary, Olympus Latin America (OLA), was charged with violating the FCPA, which makes it a crime to bribe foreign officials. DOJ alleges that between 2006 and August 2011, OLA gave $3 million worth of cash, travel, grants and other goodies to health care practitioners at government-owned facilities in Central and South America to get them to buy Olympus products. Again, OLA entered into a DPA for its alleged FCPA violation and will pay $22.8 million in fines, DOJ says. If Olympus drops the ball, DOJ will prosecute.

The reason for DPAs is they allow companies to avoid Medicare exclusion, which is mandatory when there’s a felony conviction. But if companies, such as Olympus, play fast and loose with a DPA, the hammer drops, and they may be convicted of a crime. Meanwhile, Olympus also has to abide by the CIA imposed by OIG. It’s another layer of compliance requirements. The CIA includes a number of compliance reforms, including implementing a code of conduct, training and education, and policies on fee-for-service arrangements with health care professionals for travel, education, speaker programs and advisory boards to ensure they are lawful.

The relationship between medical and pharmaceutical device manufacturers and their customers, such as hospitals and physicians, can be a minefield. Manufacturers have to report payments to physicians and teaching hospitals that are more than $10 to the open payments program, a publicly available database administered by CMS under the Sunshine Act, and, unrelated to that, hospital-employed physicians are required to report them on conflict-of-interest disclosure forms. The fear is that money influences medical decision making, and if legal requirements aren’t met, the anti-kickback law may be violated.

Angelette says compliance officers have their work cut out for them when money is rolling into physicians’ pockets and into the hospital. “It’s impossible for compliance officers to wage war against all the big producers

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without leadership behind them,” he says. “It’s even worse to have an ‘ineffectual’ compliance officer than no compliance officer because you have documentation created internally saying you know” what’s transpiring inside the hospital.

Education is step one, and never take anything for granted, Angelette says. “Make sure physicians are educated on the fact that these types of inducements are inappropriate,” he says. “It limits your liability if you can show you educated them on not taking six-figure consulting fees or get free equipment — ‘the hospital should investigate the vendor.’ Do you guys have a compliance program? Can you talk us through why it is OK for you to provide us with those things? We need a fair-market value indication of why the consulting agreement provides value,” Angelette says. “Start asking for the underlying legal meat of this. If they can’t provide it, that’s when you start to back away.”

Risky arrangements should be identified by auditing and monitoring, a hallmark of effective compliance programs, says Fort Lauderdale, Fla., attorney Gabe Imperato, with Broad and Cassel. “It’s true that even an effective compliance program won’t eliminate all risks, but it could certainly reduce criminal exposure, substantial civil liability and even liability for individuals,” he says. When health care organizations are cavalier about compliance programs, it won’t be long before compliance officers take the hint and notice that “business judgments” will override compliance necessities, Imperato says. “If you identify risk areas and propose a remedy, either the organizations will effectively implement the remedy or they won’t. If it’s the latter, they still have the risk,” he says. The compliance officer may have to leave, but the organization is naïve to think it will just skate. There are too many whistleblowers and other enforcement actions, he observes.

An attorney for Olympus did not return RMC’s calls. Olympus did not admit liability in the civil settlement. In a statement on its website, Olympus Corp. of the Americas President and CEO Nacho Abia says, “Olympus leadership acknowledges the Company’s responsibility for the past conduct, which does not represent the values of Olympus or its employees. Olympus is committed to complying with all laws and regulations and to adhering to our own rigorous Code of Conduct which guides our business processes, decisions and behavior. The Company has implemented and will continue to enhance its robust compliance program.”

Contact Angelette at sangelette@polsinelli.com and Imperato at gimperato@broadandcassel.com. Read the press release at http://tinyurl.com/zk2v8xu.

NEWS BRIEFS

◆ The former owner and operator of Recovery Home Care Inc. and Recovery Home Care Services Inc. (collectively RHC) agreed to pay $1.75 million to resolve false claims allegations that he caused RHC to pay physicians kickbacks to refer Medicare patient for home health care, the Department of Justice (DOJ) said March 2. Mark Conklin was accused of masterminding a scheme from 2009 through 2012 to pay physicians to do quality reviews of patient charts, but they allegedly did little or no work, DOJ said. The point was to get the physicians’ referrals to RHC, DOJ alleged. In October 2012, Conklin sold RHC to National Home Care Holdings LLC, which settled with DOJ for $1.1 million in March 2015. Visit http://tinyurl.com/zot32cl.

◆ HHS and DOJ released their fiscal year 2015 report on the Health Care Fraud and Abuse Control (HCFAC) program. HCFAC, which coordinates federal, state and local health care fraud enforcement activities under the agencies’ joint direction, recycles recoveries into more enforcement. “The return on investment (ROI) for the HCFAC program over the last three years (2013-2015) is $6.10 returned for every $1.00 expended,” the report states. In FY 2015, the feds “won or negotiated over $1.9 billion in judgments and settlements” and got “additional administrative impositions in health care fraud cases and proceedings.” Visit http://tinyurl.com/jodv3tm.

◆ Connecticut podiatrist Amira Mantoura was sentenced to three years of probation for ripping off Medicare, Medicaid and private payers, the U.S. Attorney’s Office for the District of Connecticut said March 1. Mantoura pleaded guilty to one count of making a false statement to Medicare in connection with claims she submitted for nail avulsions that she did not actually perform from January 2009 to August 2013, the U.S. attorney’s office said (RMC 10/12/15, p. 8). She paid a $266,000 fine and will be excluded from Medicare and other federal health programs. The podiatrist also agreed to settle a false claims lawsuit for $288,538 and will be required to perform 200 hours of community service. Visit www.justice.gov/ct.

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